Women, Work and Health: Some Challenges to Health Promotion[1]

SUSAN A. McDANIEL[2]

With greater proportions of women spending more of their working lives outside the home, the worksite may be an excellent place for health education and promotion among women. Building opportunities into the work day for information and counselling sessions, education about worksite health hazards, as well as programs for exercise, weight control, smoking cessation and stress reduction could be an important means of addressing the health needs of working women. Given the longer life expectancy of women when compared to men, health promotion of this sort might enable more women to spend more of their lives in good health.

Too often, biases about work encourage us to overlook women as workers while focussing on men. It has long been assumed that women work at jobs and in situations with fewer health risks than men. This has been shown to be incorrect. Women who work face health risks that differ from those of men including hazards to reproductive health, threats of violence, sexual harassment (now a compensable work injury in Quebec), as well as risks associated with doing sedentary, confining work. Women's particular challenges in balancing the demands of work and family, for which they still bear central responsibility in the domestic division of labour, pose additional health risks.*

In this paper, some of the issues and challenges involved in worksite health promotion for women are highlighted. Some principles are derived from this brief overview on which future policies and programs may be built. In subsequent papers, the specific challenges associated with reproductive health, mental health, aging, AIDS and infertility among working women will be addressed.

Maintenant que des proportions croissantes de femmes passent de plus en plus de temps à travailler à l'extérieur de la maison, le lieu de travail peut constituer un excellent endroit pour de l'éducation et de la promotion de la santé auprès des femmes. La création d'occasions au cours de la journée au travail pour organiser des sessions d'information et de conseil, d'éducation à propos des risques pour la santé sur les lieux du travail, de même que des programmes de conditionnement physique, de contrôle du poids, de cessation de fumer et de réduction du stress, pourrait constituer une façon importante de prendre en compte les besoins de santé des femmes au travail. Etant donné la plus longue espérance de vie des femmes par rapport à celle des hommes, un programme de promotion de la santé de ce type pourrait permettre à plus de femmes de passer une plus longue partie de leur vie en bonne santé.

Trop souvent, des conceptions erronées au travail nous encouragent à ignorer les femmes au travail, au profit des hommes. On a longtemps cru que les femmes effectuaient du travail ou se retrouvaient dans des situations qui comportaient moins de danger que pour les hommes. On a pu constater que c'était inexact. Les femmes qui travaillent+ font face à des dangers pour la santé qui diffèrent de ceux des hommes, dont les risques pour le système de reproduction, les menaces pour la violence, le harassement sexuel (un accident de travail qui est maintenant sujet à des compensations au Québec), de même que les risques associés au travail sédentaire et cloîtré. Le défi spécial pour les femmes en termes d'équilibre entre les exigences du travail et celles de la famille, pour lesquelles elles ont encore la responsabilité centrale pour ce qui est de la répartition du travail domestique, suscite des dangers additionnels pour la santé.

Dans cet article, certaines des questions et certains des défis posés par la promotion de la santé des femmes sur les lieux du travail sont évoqués. On dégage certains principes à partir de cette brève vue d'ensemble et on espère pouvoir définir éventuellement des politiques et programmes à venir en conséquence. Dans des articles subséquents, on évoquera les défis spécifiques liés au système de reproduction, à la santé mentale, au vieillissement, au SIDA et à l'infertilité parmi les femmes au travail.

The complex relationships between work and health among women have proven to be something of a conundrum. At least three sets of causal links are possible: 1) employment can affect health; 2) health can affect employment; or 3) a third set of factors, such as marital status, income or education can affect both health and employment. Adding further complexities are myths and biases about women's work, the hidden or overlooked health risks faced by women at work, and the lack of adequate research on working women who are still seen as

1. Paper prepared for the series of the Centre for Applied Health Research (CAHR), University of Waterloo.
2. Department of Sociology/Health Studies, University of Waterloo.

*For the sake of brevity, the phrase "women who work" will imply women who work outside the home.

exceptional, despite the fact that a majority of Canadian women now work.

In this brief review, I summarize what is known about women, work and health, dispelling some myths and misconceptions. I examine the particular and often unrecognized health risks faced by women who work. In light of what is known, I explore some challenges in developing health promotion programs for women at the worksite, and offer a critique of the problems which characterize worksite health promotion efforts. Finally, I suggest some principles which might be useful in guiding the establishment of health promotion programs for working women in the future.

Women, Work and Health: What is Known?

Less is known about working women's health risks and benefits and the relationship of work and health among women than should be.[1,2,3] Work has been assumed to be what men do.[4,5] Research has largely focussed on men and men's health risks at work to the neglect of women. The findings of some studies of men are then generalized, often inappropriately, to women.[4] The problem of bias is exacerbated by the widely held assumption that men's higher mortality, when compared with women's, results from their greater exposure to health risks at work.

Women who are housewives have long been assumed to have limited health risks, an assumption being increasingly questioned as research accumulates.[3] As more women join the paid work force, it has been predicted that women's rates of morbidity and mortality will increase, although this is being challenged.[4] The logic is clear, although the evidence less so — that work is hazardous to health and that as women increasingly assume a male pattern of work, their health will suffer, as men's health has suffered in the past. This assumes that work is a primary stressor and risk source, whereas home is a sanctuary from stress. The implicit assumption is that women's home-based roles are "natural" and therefore freer of stress than work.[4] A class bias is also present in this thinking since it was middle and upper class women who remained at home (and still do) to a larger extent than poor or working class women. The class position of housewives relative to working women may artificially inflate the finding that women at home experience less stress than women who work.

Research evidence on the effects of employment on women's health is mixed, but suggests increasingly that employed women tend to have better health than housewives.[2,3,4,6,7,8] A number of recent studies have shown that the health of employed women is significantly better, both mentally and physically, than the health of women at home,[9,10,11] and that contrary to popular belief, women in occupations with higher status experience even more advantages to health.[3,11] Waldron[3] reports findings from many studies in the United States which show that employed women generally rate their health as better than housewives, and women who enter the work force after being housewives experience improved health. It may be as Lapierre[8] suggests that "the remuneration (even minimal) received by women working outside the home confers a certain prestige that housewives do not enjoy." This prestige may translate into better self-perceived health.

However, the effects of health and lifestyle on employment may confound the neatness of this relationship. For example, Waldron[3] reports that housewives are more likely to experience chronic health problems than employed women. It may be that these problems prevent them from seeking employment, while employed women might be "selected" into employment by their excellent health and high energy levels. However, selection factors may account for only a small portion of the differences. An impressive number of studies have found that housewives experience a much higher risk of depression than employed women.[4] Housewives could also have more opportunities, or fewer deterrents, to be sick and visit doctors. Lapierre[8] reports that in Canada, nearly twice as many housewives as employed women visited a doctor ten or more times in the year preceding her study.

The effects of health on women's employment may be less clear-cut than for men. Women may less often seek, or have the option of seeking, disability benefits. They may, therefore, be "hidden" in data and studies, as housewives rather than as unemployed, disabled, or unemployable workers. Some support for this hypothesis is found by Waldron[3] who notes that the proportion of U.S. housewives who give poor health as their reason for not working is roughly equivalent to the excess in chronic illness of housewives over employed women. Chronic illness may also inhibit women to a greater extent than men in seeking employment due to the lesser demand for female labour and discrimination against women.

The findings of positive effects of employment on women's health tend to overlook specific health risks faced by working women. These might be grouped into four overlapping categories: occupational hazards, stress, family and social roles, and lifestyle. In terms of occupational hazards, the general assumption that women face fewer risks than men because of the type of work they do is being questioned, although there is little doubt that the risks are different. Women of childbearing age face particular risks if they work with toxic substances, not only to themselves but to their unborn children.[5,12] Clerical workers may be exposed to hazardous levels of ozone, methanol and other chemicals from copying machines,[2,3,13] as well as the possible risks associated with prolonged use of video-display terminals. Health care workers, of which women comprise the majority, face hazards related to infection (now including AIDS, back strain and injury from lifting patients; and among operating room personnel, there are risks of miscarriage and cancer due to exposure to anesthesia. Women in most occupations have less

opportunity than men to avoid secondhand smoke in the workplace, because they more often work in lower paid jobs without the possibility of control or the perks of status.

Stress, family roles and lifestyle merge as health risks for employed women. Women more often than men work in monotonous, poorly paid, insecure jobs which have been found to be associated with lowered psychological and physical well-being.[3,4,14,15,16] Women more often than men face job-worker mismatch as a result of discrimination, which has been found to be related to elevated stress and alienation.[14] Although housewives and employed women both face stress associated with doing boring work not under one's control, the stresses may be different.[3,4] Women's responsibility for home and child care, whether or not they also work outside the home, can result in the stresses of work and role overload.[4,17,18] Women more often take the blame for family stress, which may add to stress-induced illness.

Lifestyle effects on health among employed women are variable. Slightly more women who work smoke, particularly among older workers in the U.S.,[3] but few differences have been found in Canada.[8] A slight tendency for employed women to drink more has been found,[8] but alcohol consumption for both housewives and employed women increases as income rises. Women who work have a tendency, on average, to be slimmer than women who are housewives, thus reducing their health risks somewhat. Women supporting families on their own, whether married or not, face the enormous stress of trying to live on an inadequate income at the same time as balancing family and work responsibilities.[19]

In addition to these problems, women who work may face sexual harassment or threats of violence in the workplace, or in going to and from the workplace. The peculiar conjunction of women's lower economic status and women's sexual position produces sexual harassment which undercuts women's potential in two ways: by using their employment position to coerce them sexually and by using their sexual position to coerce them economically.[20] The suffering and fear of job loss associated with sexual harassment has led the Province of Quebec to declare that sexual harassment is a compensable work injury.[21] Threats of assault and/or fear of assault either on the job or in going to or from the worksite also elevate women's anxiety levels and curtail their opportunities. These factors have been recently acknowledged as having health consequences for women.[20,21]

Challenges to Worksite Health Promotion for Working Women

With greater proportions of women spending more of their lives in paid work, the worksite might be seen as an excellent and underutilized place for health education and health promotion. Clear opportunities are provided for building into the work day programs intended to reduce illness and disability, and to encourage healthy lifestyles and habits. The potential benefits from such efforts could include reduced absenteeism and stress-related illnesses and problems, happier employees with healthier and possibly longer lives, reduced health care costs and reduced disability and survivors' benefits. A bonus of programs directed at women might be that they, as principal caretakers and socializers of children, could convey to their children what they have learned. What are the challenges to developing such programs, given the current state of knowledge about women, work and health?

Despite the impressive strides made recently in understanding health, much remains to be known. As Van Loon states, "Beyond a few relatively well-known principles, there still remains some doubt about what 'causes good health' and a great deal of doubt about the efficacy of government [or anyone else] in promoting even those factors we can identify."[22] Health promotion, although undeniably important and likely the way of the future, is in its infancy compared to the emphasis and vast amount of research done on the medical aspects of illness and cure. Health promotion still exists as an alternative perspective with all the connotations, good and bad, inherent to any alternative approach. It also faces challenges as a result of its orientation which have little to do with its relative youth.

The growing number of critiques of health promotion, as it is presently defined,[23,24,25,26] call attention to potential problems and limitations. In summarizing some of these critiques here, I intend to highlight their relevance to the development of worksite programs for women rather than provide any comprehensive critique. Central to health promotion is the definition of individuals as consumers rather than as workers.[26] This leads to the focus in health promotion on lifestyles, diet, consumption, exercise, levels of expectations, personality type, smoking habits and utilization of health services. Programs aimed at wellness become individualized,[24] despite their mass participation. Other factors crucial in the creation of illness such as poverty, occupational hazards, socio-economic inequality, racism, sexism, and environmental pollution are deemphasized as health problems.[23,24,26] Navarro[26] further argues that the place of work in organizing social life, including health, illness and death, tends to be overlooked by health promoters, thus rendering health a commodity to be bought and sold by individuals rather than a political or social force. Navarro gives an example: the American Health Foundation, a prestigious forum for the U.S. medical establishment, has recommended placing older workers in jobs where exposure to carcinogens occurs, on the assumption that they will die before they develop cancer!

A further criticism of health promotion programs is that their orientation is such that they may overlook those who need them most.[24,27] This stems from a set of interrelated problems with health promotion: 1) it tends to be directed

toward those who believe that individual effort will pay off, largely white-collar workers; 2) it encourages individuals to take control of their lives, something not easily possible for the poor, the working class or the unemployed; 3) it is often focussed toward those whose companies stand to gain the most, such as executives and managers; and 4) the structural components of health and work tend to be overlooked, so that it may not be recognized that some blue collar employees worry that health-testing could cost them their jobs. For all of these reasons, worksite wellness or health promotion programs must be implemented with sensitivity and awareness of not only the worker's situation, but also the limitations of the health promotion approach itself.

What implications might this discussion have for the development of worksite programs of health promotion for women, given the current state of knowledge about women, work and health? First, worksite health promotion programs developed for men, particularly upper management men, are not fully appropriate for women.[28,29] Women work in different structural situations with less control over their work and lives generally,[28] with less acceptance that individual effort pays off (it often doesn't for women who work hard but still get less pay and less opportunity than men), with more role overload, with less flexible working hours, and perhaps most importantly, with the prevalent belief that women are not really workers after all. This latter belief means that women's work-related health risks are more often overlooked or dismissed on the grounds that if they cannot take it (implicitly "like a man"), then perhaps they should not be working.[30] Worksite health promotion programs for women must be created *for* women and be free, insofar as they can be in male-dominated society, of male biases.

Second, health promotion programs for women workers should attend as much to the particular workplace hazards and risks faced by women as to promoting wellness. The structural place of women in the work force, for the most part, is such that many feel they must tolerate risks to keep their jobs in order to feed their children and pay the rent. This is similar to the position of many blue collar workers who may be reluctant to complain about health hazards at work for fear of losing their jobs or having the company close. Women, however, face additional problems. Among these are the fact that women are less often unionized and hence vulnerable to job loss, and to having no collective voice for their health concerns. Women also face different job-related health risks than men do, as seen earlier. These, women workers fear, might cause employers to fire pregnant women or women of childbearing age or to discriminate against women workers more seriously, since they could be seen as too delicate to handle hard work. Fee[31] cites the case of four women workers at American Cyanamid who underwent sterilization operations in order to keep their jobs. Complaints about reproductive risks women face is used to justify continued lower wages for women as well. In this climate, if a company offers a health promotion program with fitness-testing, it is easy to imagine how it might be viewed with suspicion by some women workers. Some women might fear job loss if they prove to be unfit for work. Others might feel that they, as individuals, are being held responsible for their own health maintenance in a situation in which the company itself risks their health with impunity.

Third, women tend to be intimately acquainted with the phenomenon known as victim-blaming. For example, if a poor woman's child falls down stairs that are structurally unsound or eats peeling apartment paint, the woman is held accountable for not being a good mother.[32,33] Similarly, if a woman is sexually assaulted, no matter what her age, appearance or dress, police and judges often hold *her* responsible for being too alluring or being in the "wrong place at the wrong time." Health promotion has the potential of inducing guilt and added stress in working women who already face role overloads, by holding *them* responsible for their health problems as individuals. This is a potentially serious problem in mounting worksite health promotion programs for women. Sensitivity to women's situations, not only at work but in society, must be built into wellness programs in order for them to have the desired effects of reducing stress and improving well-being.

Fourth in a less than comprehensive list, in implementing worksite health promotion programs for women, the concept of health promotion as it now exists may need broadening. Rather than focussing only on the traditional concerns of weight control, exercise, stress reduction, diet, smoking cessation, etc., some attention might be given to recognizing the health promotion possibilities inherent in addressing women's structural problems in the workplace. For example, improving opportunities for women to earn more, be promoted, have dignity in the workplace, or have on-site day care, could go a long way towards promoting the health of women workers. Similarly, serious attention to the health problems women at work face as a result of sexual harassment and assault might reduce women's stress and improve their health. Recognition by employers that women face multiple responsibilities at work and at home, but without penalizing them for this, may reduce women's stress and enhance well-being. This could have the further beneficial effect of granting male workers and employers permission to admit their own family stresses (and joys), thereby possibly reducing their stress as well.

Conclusion

In this brief examination of the challenges to developing worksite health promotion programs for women, it is apparent that the need exists for such programs. Despite the fact that employed women are generally in better health than housewives, employed women face health risks, some of them quite serious, that could be addressed in part by sensitive, carefully designed health promotion programs.

Given that the majority of Canadian women now spend a substantial portion of their lives working outside the home, it seems important to address the health needs of working women. The worksite could be an excellent place in which to do this. Given women's longer life expectancy when compared to men and their greater utilization of health care as they age, successful worksite health promotion programs could enable more women to live more of their lives in a healthy state. It is clear, however, from this examination of what is known about women's health and work and about health promotion, that program development for women workers, to be successful, will have to account for women's different situations, both at work and in society.

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